



*Florida Breast &  
Cervical Cancer Early  
Detection Program*

# FBCCEDP Eligibility

## **Eligibility for *Breast and Cervical Cancer Screening*:**

- ♦ **Female, age 50 to 64**
- ♦ **Resident of Florida**
- ♦ **No insurance, or medically needy**
- ♦ **Income at or below 200% of federal poverty guidelines**
- ♦ **Not screened within the prior year.**
- ♦ **A client age 40 to 49 with CBE suspicious for cancer may be eligible for limited diagnostic funds as available**
- ♦ **Under age 40 case by case review.**

**For an application please contact your local  
Florida Department of Health or  
Participating Medical Group**

Each application will be reviewed by program staff or manager for eligibility criteria. On approval, a voucher will be issued to the primary provider to schedule the next available appointments for eligible services. Women may enroll at any Florida Department of Health or participating medical group in our regional area.

Referrals for further diagnostics and services will be made by primary provider after authorization for reimbursement from the regional office.

Application for Medicaid Treatment Act funds eligibility will be done by program manager when pathology report for cancer is received.

- Clinical Breast Exam
- Pap (if no hysterectomy)
- Screening mammogram
- Diagnostic imaging
- Biopsy assistance
- Medicaid application with cancer diagnosis

FBCCEDP/FDHPC  
Regional Site Office  
2801 Kennedy Street  
Palatka, Florida 32177  
386-326-3200 ext:3281

Serving Alachua, Bradford,  
Columbia, Dixie, Gilchrist,  
Hamilton, Lafayette, Levy,  
Putnam, Suwannee, and  
Union counties.

# Florida Breast and Cervical Cancer Early Detection Program

## Annual Applicant Agreement

- I agree to become a client of the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP).
- Florida is my primary residence.
- I declare that my net family annual income is at or below 200% of the federal poverty guideline and I have no health insurance that pays for breast and cervical cancer screening exams.
- I understand I am no longer eligible for the FBCCEDP if my income changes to be above 200% of the federal poverty guideline or if I enroll in any health insurance program that provides breast and cervical cancer screening.
- I understand that I may have a share of cost for some services.
- I agree to use an authorized provider for my breast and/or cervical screening examinations (breast exam, mammogram, and/or Pap test) and I agree to complete any follow-up tests within 60 days.
- I understand that the FBCCEDP is a breast and cervical cancer **screening** program, not a cancer **treatment** program. If I am diagnosed with breast or cervical cancer as a result of my FBCCEDP screening, I will be referred to a provider for my cancer treatment. I understand I can reapply to the FBCCEDP for screenings after initial treatment is completed.
- I agree to allow an exchange and release of information via fax or mail between my health care providers, the Florida Department of Health Breast and Cervical Cancer Early Detection Program, the Florida Department of Health Cancer Data Registry, the Centers for Disease Control and Prevention, and others related to my health care. This information could include medical history, examination results, and any follow up tests and treatments done as a result of the examination, even if the tests or treatment I receive are not paid for by the FBCCEDP.
- I agree to receive phone or mail contact from FBCCEDP staff about my health care.
- I understand this agreement is good for one year unless my program eligibility changes.
- I understand that taking part in this program is my choice and I may withdraw from the program at any time.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date of birth

Revised 04/2014





**FLORIDA BREAST AND CERVICAL CANCER EARLY DETECTION SCREENING PROGRAM**  
**PATIENT ENROLLMENT/REFERRAL FORM (PRF)**

The Florida Department of Health in Putnam County invites you to take part in the Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP). If you qualify, you may receive your breast and cervical cancer examinations free. If your test results are not normal, FBCCEDP will work with your doctors to help you obtain additional tests and, if needed, treatment.

**There may be some cost to you for some tests if you have abnormal results and need diagnostics or treatment.**

Serving Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties

**IDENTIFICATION/GENERAL INFORMATION**

**All fields must be completed for application to be processed.**

**NAME:**

Last

First

MI

**Mailing**

**ADDRESS:**

**Street**

Street

City

Zip

County

**ADDRESS:**

Street

City

ZIP

County

**PHONE:**

( )

**Other Contact Phone**

**SSN:**

**Date of Birth:**

**AGE:**

**Tobacco Use**

1) ☐ Daily

2) ☐ Some Days

3) ☐ Not at all

4) ☐ Declined to answer

We offer a free smoking cessation program. Would you be interested in entering our smoking cessation program?

☐ Yes ☐ No

**BREAST EXAM BACKGROUND (Check only one box for each category)**

Have you yourself ever been diagnosed with BREAST CANCER? ☐ YES (year ) ☐ NO **Implants:** Yes/No? How long?

**Family Hx:** Yes/No? **Circle:** Grandma/Grandpa Mother/Father/Aunt/Sister/Brother?

When was your last MAMMOGRAM: (month /year ) ☐ NONE ☐ Unsure (5+ years?)

Where was it done? (PROVIDER)

**Height**

**Weight**

**BP**

**Hx of Hypertension / High Blood Pressure?** Yes / No?

Diabetes? Yes / No? Type:

**CERVICAL EXAM BACKGROUND**

Have you yourself ever been diagnosed with invasive cervical CANCER? ☐ YES (year ) ☐ NO

When was your last PAP SMEAR exam (month /year ) ☐ NONE ☐ Unsure (5+ years?)

**HYSTERECTOMY** Yes/No (Partial/full) When? **Cervix** Yes/No?

**PROGRAM DATA: RACE** – Check or circle ALL that apply:

☐ AMERICAN INDIAN or ALASKAN NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN

☐ NATIVE HAWAIIAN or Other PACIFIC ISLANDER ☐ WHITE ☐ OTHER (PLEASE DEFINE)

**PRIMARY LANGUAGE:** ENGLISH / SPANISH

**ETHNICITY:** HISPANIC OR LATINO? YES / NO



**INCOME/INSURANCE INFORMATION:** *(Required information. Please check or circle all that apply.)*

Check if you are receiving any of the following:

Medicare A Yes/No Medicare B Yes/No Medicaid Yes/No  
Do you have any health insurance? YES Type NO

Number in Household  
Monthly Income  
Annual Income  
Unemployment

**Client Agreement**

- I understand that no test is 100% accurate.
- This statement is true at the time it is made. I understand that the provider shall attempt to verify the statement. Verification can be secured by telephone, in written form, or by face-to-face contact; verification does not require a written document to confirm an applicant or client's statement. If the provider is unable to verify wages paid or an employer will not verify wages paid, the signed self-declaration statement provided by the applicant must be accepted as accurate.
- I have read or had the above read to me. I agree that the information I have provided is correct.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please Print Name: \_\_\_\_\_

Referred By: \_\_\_\_\_

PLEASE ATTACH ANNUAL APPLICATION AGREEMENT FORM SIGNED AND DATED. THANK YOU!



## AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

### INFORMATION MAY BE DISCLOSED BY:

Person/Facility: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

### INFORMATION MAY BE DISCLOSED TO:

Person/Facility: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Other method of communication: \_\_\_\_\_

### INFORMATION TO BE DISCLOSED: (Initial Selection)

\_\_\_\_ General Medical Record(s), including STD and TB      \_\_\_\_ Progress Notes      \_\_\_\_ History and Physical Results  
\_\_\_\_ Immunizations      \_\_\_\_ Family Planning      \_\_\_\_ Prenatal Records      \_\_\_\_ Consultations  
\_\_\_\_ Diagnostic Test Reports (Specify Type of test(s)) \_\_\_\_\_  
\_\_\_\_ Other: (specify) \_\_\_\_\_

### I specifically authorize release of information relating to: (initial selection)

\_\_\_\_ HIV test results for non-treatment purposes      \_\_\_\_ Substance Abuse Service Provider Client Records  
\_\_\_\_ Psychiatric, Psychological or Psychotherapeutic notes      \_\_\_\_ Early Intervention      \_\_\_\_ WIC

### PURPOSE OF DISCLOSURE:

\_\_\_\_ Continuity of Care      \_\_\_\_ Personal Use      \_\_\_\_ Other (specify) \_\_\_\_\_

**EXPIRATION DATE:** This authorization will expire (insert date or event) \_\_\_\_\_. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

**REDISCLASURE:** I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

**CONDITIONING:** I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

**REVOCATION:** I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

\_\_\_\_\_  
Client/Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Representative's Relationship to Client

\_\_\_\_\_  
Witness (optional)

\_\_\_\_\_  
Date

Client Name: \_\_\_\_\_

ID#: \_\_\_\_\_

DOB: \_\_\_\_\_